STATE OF NH APPLICATION FOR SUPPLEMENTAL SICK LEAVE

Important: All fields of the application must be completed. An incomplete application may lead to denial of your request for Supplemental Sick Leave.

Part I – to be completed by the employee or designee.

PLEASE PRINT OR TYPE – ALL FIELDS MUST BE COMPLETED

1. Name:		**2.** Job Title:
3. Agency:	**4.** Department/Division:	
5. Are you covered by the SEA Bargaining Unit?	❑ Yes	❑ No
6. Work Phone:		**7.** Home Phone:
8. Home Address:		
9. Have you previously filed for SSL?	❑ Yes	❑ No
(a) If yes, when?	(a)_____Month	_____ Year
(b) For what condition was the leave approved?	(b)_____	
10. I am requesting _____ days of supplemental sick leave.		
11. Is your injury or illness work-related? ❑ Yes- **Stop here**, your application cannot be processed if your injury or illness is work related. *(Please note: In the event of a work-related medical condition, SSL would not be considered by the LMC until the workers' compensation process has been completed – please discuss with your Human Resources representative.)* ❑ No- Please **describe reason** for request below.		
12. Describe reason(s) for your request in detail. Please include the date of injury or commencement of illness: (a) Include information relative to your diagnosis, course of treatment, and why you cannot return to work at this time. (b) Identify whether your condition is ongoing or not.		

Part I – Continued

13. Are there extenuating circumstances as to why you are out of paid leave (paid leave includes sick leave, annual leave, floating holidays, bonus days, and compensatory time)? Please describe:

PLEASE NOTE: Your physician or medical provider must complete Part II of this application and the stated diagnosis, treatment plan and prognosis provided must support this application. The physician or medical practitioner must provide all of the information requested on Part II of this form and he/she must sign and date the form.

In requesting supplemental sick leave, I agree to have my physician/medical practitioner provide the information requested in **Part II** of the application.

14. Signature: _____ **Date:** _____

15. Completed by:	❑ Employee	❑ Designee (specify): _____

16. TO BE COMPLETED ONLY BY THE EMPLOYEE. In applying for supplemental sick leave, I hereby authorize the use and disclosure of my individually identifiable health information as follows: my name, the agency I work for, the reason for my request, my last day of work, the date my leave available for this absence was or will be exhausted, and the expected duration of my absence. I understand that I may revoke this authorization by notifying the department in writing. However, the revocation will not be valid if the department has taken action in reliance on this authorization. I further understand that the information I have authorized for disclosure may be re-disclosed and no longer protected by federal privacy regulations.

Signature: _____ Date: _____

Part II - to be completed by the employee's physician or medical practitioner.

Important: Forms which are incomplete may result in denial of the employee's application for Supplemental Sick Leave.

The employee named in **PART I** has applied to receive supplemental sick leave through the Supplemental Sick Leave Program established by the State of NH. You are requested to complete the information below for this individual patient.

PLEASE PRINT OR TYPE– ALL FIELDS MUST BE COMPLETED

1. Patient's Name/Address:		**2.** Most recent date of examination:	
3. The patient is/was:	❑ Under my professional care	From:	To:
	❑ Hospitalized (N/A if not applicable.)	From:	To:
4. Is the patient's health condition work-related? (If yes, please explain.)		❑ Yes	❑ No
5. The patient has been incapacitated from performing his/her duties:		❑ Yes	❑ No
		From:	To:
6. Anticipated duration the patient will be unable to work due to the condition:		From:	To:
7. Will the patient need to attend follow-up treatment appointments?		❑ Yes	❑ No
		From:	To:
8. If the patient is not able to return to full duty employment, can the patient return to work at less than full duty?		❑ Yes	❑ No
(a) If yes, period of partial incapacity:		From:	To:

(b) Restriction(s) if any: _____

_____

_____

9. Describe in detail: the nature, date injury or illness commenced, diagnosis, and treatment plan of the illness, injury, impairment or physical or mental condition (please attach documentation if necessary):

a) Nature of injury/illness: _____

_____

_____

b) Date condition commenced: _____

c) Diagnosis: _____

d) Treatment Plan: _____

_____

_____

e) Prognosis: _____

_____

10. PHYSICIAN'S OR PRACTITIONER'S SIGNATURE

Name: _____ Title: _____
(Please Print)

_____ Date: _____
(Signature)

Address: _____ Phone: _____

Part III - to be completed by the employee's appointing authority or designee.

Important: All fields of the application must be completed. An incomplete application may lead to denial of the employee's request for Supplemental Sick Leave.

PLEASE PRINT OR TYPE– ALL FIELDS MUST BE COMPLETED

1. Employee Name/Address:	**2.** Job Classification:	**3.** Start Date (Date of Hire) :
4. Is the employee covered by the SEA Bargaining Unit?	❑ Yes	❑ No
5. Has the employee exhausted all paid leave (sick, annual, compensatory, bonus, floating holidays)?	❑ Yes	❑ No
(a) If not, what are the employee's leave balances?	(a) _____	
(b) The employee's leave available for this absence was/will be exhausted on (date):	(b) _____	
(c) How much leave time has the employee used since the onset of the medical condition?	(c) _____	
6. Has this employee filed previous requests for SSL?	❑ Yes	❑ No
(a) If yes, indicate date(s) and amount(s) of leave approved:	To:	From:
7. For this absence, is the employee receiving/eligible to receive workers' compensation benefits or is there a pending workers' compensation appeal?	❑ Yes	❑ No
8. The employee is expected to be absent from work until (date):	_____	
9. Date illness/injury began:	_____	
10. Has the employee been counseled or disciplined for unsatisfactory attendance during the last 12 months?	❑ Yes	❑ No
(a) If yes, please check appropriate box.	❑ Counseled	❑ Disciplined
(b) Please **explain** the counseling or discipline: _____		
_____		
_____		

11. I recommend approval of the request:

❑ Yes ❑ No

(a) If yes, how many days? (Please calculate anticipated accruals in this amount.) _____days

12. If **RECOMMENDED IN PART** or **NOT RECOMMENDED**, describe reason(s) below or on a separate sheet.

Your recommendation is confidential and should not be shared with the requesting employee. Please return this form directly to the Bureau of Employee Relations, Division of Personnel.

13. APPOINTING AUTHORITY OR DESIGNEE

Name: _____ Title: _____
(Please print)

_____ Date: _____
(Signature)

14. HUMAN RESOURCES

Name: _____ Title: _____
(Please Print)

_____ Date: _____
(Signature)